PATIENT REGISTRATION

NAME: _____ DATE: _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____ SEX: M / F MARITAL STATUS: M S W

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECIRITY #: _____

LANGUAGE: ENGLISH / SPANISH / OTHER _____

RACE: WHITE / BLACK OR AFRICAN AMERICAN / HISPANIC / ASIAN / OTHER _____

ETHNICITY: HISPANIC ORIGIN / NON HISPANIC ORIGIN / DECLINE TO ANSWER

EMPLOYMENT STATUS: ACTIVE RETIRED DISABLED STUDENT N/A

PATIENT'S EMPLOYER/SCHOOL: _____

OCCUPATION/GRADE: _____ WORK PHONE # : _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE #: _____ REFERRED BY: _____

FAMILY PHYSICIAN/INTERNIST: _____ PHONE #: _____

PHARMACY NAME/LOCATION/PHONE #: _____

APPROXIMATE DATE OF LAST EYE EXAM: _____

HAVE YOU EVER WORN CONTACT LENSES?: Y / N IF YES, WHAT TYPE?: _____

ARE YOU STILL INTERESTED IN WEARING CONTACT LENSES?: Y / N

I AUTHORIZE DR. DOROTHY PARK & ASSOCIATES TO RELEASE ANY MEDICAL INFORMATION NEEDED TO DETERMINE BENEFITS FOR RELATED SERVICES TO MY INSURANCE COMPANY, WORKMAN'S COMPENSATION CARRIER, OR ANY OTHER REIMBURSEMENT AGENT.

I HEREBY ASSIGN ALL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE AND OTHER HEALTH PLANS TO DR. DOROTHY PARK & ASSOCIATES. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED VALID AS AN ORIGINAL.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE. FURTHERMORE, I AGREE TO PAY ALL REASONABLE FEES AND COLLECTIONS COST SHOULD SUCH BE NECESSARY TO COLLECT PAYMENT ON THIS ACCOUNT. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION TO SECURE THE PAYMENT.

RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT

I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE READ AND UNDERSTAND IT.

SIGNED/RESPONSIBLE PARTY: _____ **DATE:** _____

BestCareInSight.com

PAYMENT AND APPOINTMENT POLICIES

You can always depend on our dedicated Doctors and Staff to provide you with the very "Best Care In Sight"!

By following the simple guidelines below, we can keep our fees at a fair level that reflects the quality of care you deserve and that we provide.

Fees: Payment of services is expected on the day of your exam. When appropriate, the insurance co-pay will suffice.

Insurance: We know that insurance is confusing and frustrating!

Before any special medical test, we can estimate your out of pocket portion.

We file most major insurances for your convenience, it is your responsibility to follow up with them if payment is not received within 30 days of filing. Ultimately any outstanding balance will to your responsibility if not paid by insurance.

Remember, we cannot negotiate with your insurance company. Any disputes regarding their payment will be between you and your insurance carrier.

If for any reason your Exam, Testing, and/or Materials balance is unpaid by 120 days, your account will be charged $100.00 and will go to a Collection Agency.

Appointments: IF YOU ARE UNABLE TO KEEP AN APPOINTMENT FOR ANY REASON, PLEASE GIVE OUR OFFICE 48 HOUR NOTICE! Our voicemail on (803) 254-6306 is available for your convenience. A 35.00 fee for repeat offenders my be charged.

Thank you!: Remember that whenever you send a new patient to our office you earn $20.00 toward the purchase of future eyewear as our "Thank You" for giving our office the greatest compliment possible!

Responsible Party's

Name _____ **Signature** _____ **Date** _____